Texas Health and Human Services Commission (HHSC)

2021 Standard Dollar Amount (SDA) Add-on Status Verification Form

July 15, 2020

In accordance with Texas Administrative Code §355.8052 (relating to Inpatient Hospital Reimbursement), the following information is required from each Medicaid-enrolled hospital and will be used in the calculation of the hospital's final Standard Dollar Amount (SDA).

INSTRUCTIONS

Please complete each of the following sections. After completion, please submit the form and any accompanying documentation via email to the UC tools mailbox uctools@hhsc.state.tx.us or mail via overnight delivery to the address provided at the bottom of the form.

PROVIDER INFORMATION

Name: _____

TPI: _____ NPI: _____ Medicare Number: _____

Contact Name: _____ Contact Email: _____

Mailing Address: _____ Physical Address: _____

City / State / Zip: _____ City / State / Zip: _____

County: _____ County: _____

INFORMATION VERIFICATION

Please select from the two below options:

☐ An error, omission, or issue exists within the FY 2021 Statewide SDA Status Verification File and a request is made to HHSC to review the error noted on the form below and the documentation included.

☐ Hospital was not reported on the FY 2021 Statewide SDA Status Verification File. All verification information must be included with the submission of the Verification Form.

ERROR IDENTIFICATION

Please identify, by marking the location of the error, omission, or other issue found within the FY 2021 Statewide SDA Status Verification File. Please use a separate document to fully explain the issue which needs to be reviewed. It is of extreme importance to verify every section identified in the list below, as we use this data to post the monthly SDA rate reports found on the Rate Analysis website.

☐ Provider NPI
☐ Texas Provider Identifier (TPI)
☐ Medicare Number
☐ Provider Name
☐ Provider Physical Street Address
☐ Provider Physical City, State, ZIP
☐ County
☐ CBSA Wage Index
☐ Applicable Teaching Add-on (Medicare Operating IME%)
☐ DSH Qualification Status
☐ Applicable Trauma Add-on (Level I-IV)
☐ Other: _____

REPORT CERTIFICATION

NOTE: Only a Corporate Officer or a Partner of the hospital may provide certification that all information is correct and accurate.

I attest that the information reported herein is true, accurate, and correct to the best of my informed knowledge and belief. After submission of this document, if I become aware of additional information that is relevant to the verification process, I will notify HHSC and resubmit data if necessary.

_____	_____
Hospital Name	TPI Number
_____	_____
Signature	Printed Name
_____	_____
Date	Title

Email Address: _____

Phone Number: _____

Email or mail the completed form and certification statement to be received no later than **August 7, 2020** to:

Rene Cantu, Director
Health and Human Services Commission
Hospital Rate Analysis
P.O. Box 149030
Mail Code H-400
Austin, Texas 78714-9030

Or for overnight or courier delivery:

Rene Cantu, Director
HHSC Hospital Rate Analysis
Mail Code H-400
4900 N. Lamar
Austin, TX 78751